98TH CONGRESS 2d Session } HOUSE OF REPRESENTATIVES { REPT. 98–1101 Part 1

MEDICARE PAYMENT FOR OUTPATIENT OCCUPATIONAL THERAPY SERVICES

SEPTEMBER 28, 1984.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 2116 which, on March 16, 1983, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2116) to amend title XVIII of the Social Security Act to authorize payment for occupational therapy services under part B of the medicare program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert:

That (a) subparagraph (C) of section 1832(a)(2) of such Act (42 U.S.C. 1395k (a)(2)(C)) is amended to read as follows:

"(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));".

(b) Section 1833(g) of such Act (42 U.S.C. 13951(g)) is amended—

(1) by striking out "next to last sentence" and inserting in lieu thereof "second sentence", and

(2) by adding at the end thereof the following new sentence:

"In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $700 shall be considered as incurred expenses for purposes of subsections (a) and (b).".

(c)(1) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)) is amended—

(A) by inserting "or outpatient occupational therapy services" after "outpatient physical therapy services",

(B) in clause (i), by inserting "or occupational therapy services, respectively" after "physical therapy services", and

(C) in clause (ii) by inserting "or qualified occupational therapist, respectively," after "qualified physical therapist".

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[new] (2) The second sentence of section 1835(a) of such Act (42 U.S.C. 1395n(a)) and section 1866(e) of such Act (42 U.S.C. 1395cc(e)) are each amended—

(A) by inserting "(or meets the requirements of such section through the operation of section 1861(g))" after "1861(p)(4)(A)" and after "1861(p)(4)(B)", and

(B) by inserting "or (through the operation of section 1861(g) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

(d)(1) section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by inserting after subsection (f) the following new subsection:

"OUTPATIENT OCCUPATIONAL THERAPY SERVICES

"(g) The term 'outpatient occupational therapy services' has the meaning given the term 'outpatient physical therapy services' in subsection (p) except that 'occupational therapy' shall be substituted for 'physical therapy' each place it appears therein.".

(2) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting "and outpatient occupational therapy services" after "outpatient physical therapy services".

(3) [new] Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting "(including through the operation of section 1861(g))" after "section 1861(p)".

(e) The amendments made by this section shall apply to expenses incurred for outpatient occupational therapy services furnished on or after the first day of the first month that begins more than 60 days after the date of the enactment of this Act.

I. Introduction

PURPOSE

The Committee bill, H.R. 2116, would extend medicare reimbursement under part B of Title XVIII of the Social Security Act for occupational therapy services provided in three settings: (1) skilled nursing facilities, as a service under part B (when there is no part A coverage); (2) clinics, rehabilitation agencies and public health agencies; and (3) the therapist's office or patient's home, where the services are provided by an independently practicing occupational therapist.

The Committee believes that the value of occupational therapy services to medicare patients, and especially the avoidance or shortening of the need for institutional care that may be possible through the appropriate provision of these services, merits a modest expansion of medicare coverage of occupational therapy services.

BACKGROUND AND NEED FOR LEGISLATION

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions that have been impaired by illness or injury or, when function has been permanently lost or reduced by illness or injury, with improving the individual's ability to perform those tasks required for independent functioning.

Under current law, medically necessary occupational therapy services are covered when provided as part of covered inpatient or outpatient hospital services, post-hospital extended care services in a

skilled nursing facility, home health services, comprehensive outpatient rehabilitation facility services, and hospice care.

II. Summary

The Committee bill would extend coverage under medicare part B to occupational therapy services in the circumstances described below and would, generally speaking, make the medicare coverage of occupational therapy services comparable to the coverage under existing law of physical therapy services.

Occupational therapy services could be provided by (or under arrangements with, and under the supervision of) a provider of services, a clinic, a rehabilitation agency, or a public health agency. Payment would be on a reasonable cost basis.

In addition, occupational therapy services furnished in the therapist's office or in the beneficiary's home could be covered. The therapist would need to meet licensing and other standards prescribed by the Secretary in regulations. Payment would be based on reasonable charges. Medicare would pay 80 percent of reasonable charges. No more than $500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary, thus, the maximum medicare payment would be $400.

Furthermore occupational therapy services furnished to an inpatient of a hospital or skilled nursing facility would be covered when the beneficiary does not have access to medicare part A coverage of occupational therapy services; e.g., when part A coverage is exhausted. Payment would be on a reasonable cost basis.

In order for occupational therapy services to be covered under the medicare program these occupational therapy services must meet several conditions. First, the services must be required because the individual needed occupational therapy services. Second, a plan of treatment must have been established by a physician or the qualified occupational therapist providing such services and be periodically reviewed by a phyician, and third, the services must be furnished while the individual is under the care of a physician.

The bill would be effective with respect to services furnished on or after the first day of the month beginning more than 60 days after enactment.

Under the recently enacted Deficit Reduction Act of 1984 (P.L. 98–369), an opportunity is provided for physicians and suppliers of services to become participating physicians and suppliers (with the participation agreements taking effect October 1, 1984, and succeeding years). The Secretary has authority under this law to accept participation agreements after October 1 in the case of new physicians and suppliers, and in similar cases that the Secretary specifies. The Committee expects the Secretary to use this authority to provide an appropriate opportunity for occupational therapists to sign participation agreements as they become eligible under the bill for services reimbursable on a reasonable charge basis.

III. Budget Effects of the Bill

1. COMMITTEE ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made: The Committee agrees that the cost estimate prepared by the Congressional Budget Office which is included below. This estimate indicates that there will be additional program expenditures under the Supplementary Health Insurance Trust Fund of $9 million in fiscal year 1985 and $14 million in fiscal year 1986.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

With respect to clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee advises that the required information pertaining to new budget authority or new or increased tax expenditures, to the extent applicable to this bill, is contained in the Congressional Budget Office cost estimate below.

3. COST ESTIMATE PREPARED BY CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by the Congressional Budget Office is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, September 27, 1984.

Hon. Dan Rostenkowski,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has reviewed H.R. 2116, a bill authorizing payment for occupational therapy services under Part B of the Medicare program, as ordered reported by the House Committee on Ways and Means on September 26, 1984.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

Eric Hanushek
(For Rudolph G. Penner, Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

September 27, 1984.

1. Bill number: H.R. 2116.

2. Bill title: A bill authorizing payment for occupational therapy services under Part B of the Medicare program.

3. Bill status: As ordered reported by the House Committee on Ways and Means, September 26, 1984.

4. Bill purpose: The bill would amend title XVIII of the Social Security Act to authorize payment for occupational therapy services under Part B of the Medicare program.

5. Estimated cost to the Federal Government:

Medicare Part B

	Millions
Fiscal year:	
1985	$10
1986	15
1987	17
1988	19
1989	22
Estimated outlays:	
Fiscal year:	
1985	9
1986	14
1987	16
1988	18
1989	21

The costs of this bill fall within budget function 550.

Basis of estimate.—The bill would extend Medicare reimbursement to occupational therapy services provided in three settings: skilled nursing facilities (as an outpatient service under Part B), rehabilitation agencies, and private practices. Medicare currently covers occupational therapy (OT) services in skilled nursing facilities (SNFs) for only the first 100 days under Part A. This bill would extend coverage to OT services after 100 days under Medicare Part B. The bill also would extend Medicare coverage of OT services in rehabilitation agencies and in private practices (with a $500 limit on services performed in private practices). Finally, Medicare payment would be authorized for certified occupational therapy assistants. The bill's costs are estimated to be $9 million in fiscal year 1985, given an effective date of January 1, 1985. The increased costs for the outyears reflect price inflation and population growth.

Because of the unavailability and uncertainty of data on occupational therapists, a precise estimate is extremely difficult. However, this bill would give the same coverage under Medicare Part B for occupational therapists as is currently allowed for physical therapists (PT) for the three settings. Since Medicare payment data for PT services in the SNFs and in private practice is available from the Health Care Financing Administration (HCFA), the costs of OT services under Medicare can be estimated for these two settings.

A comparison between OTs and PTs was developed because there are many areas of overlap in which both professions seek to improve muscle strength, range of motion, and physical endurance, with the chief difference being the specific devices used in treatment. We assumed that occupational therapy services would result in slightly lower costs per patient visit than physical therapy services. This assumption is based on salaries for physical and occupational therapists

($23,000 and $20,000, respectively, for fiscal year 1982). Because PT salaries are approximately 12.2 percent greater than OT salaries, the estimated cost of this bill is adjusted to reflect the salary difference.

As of fiscal year 1984, full-time equivalent PT and OT employees were 40,000 and 23,000, respectively. The number of employees working in the three work settings are shown below along with the ratio of OTs to PTs.

	Occupational therapist	Physical therapist	Ratio OT/PT
Skilled nursing facilities	1,380	3,200	0.43
Private practice	920	4,400	.21
Rehabilitation agencies	1,150	3,600	.32

In the SNF setting, outpatient reimbursements for PT services are estimated at $17 million for fiscal year 1985, based on information from the HCFA's Office of Program Quality Evaluation. Given the ratio of occupational therapists to physical therapists, and given the slightly lower salary levels of occupational therapists, we estimate the Medicare cost of coverage for OT services in the outpatient SNF setting at $5 million in 1985, given an effective date of January 1.

In private practices, according to HCFA's Medicare Part B Bill Summary Data, the reimbursement for PT services totaled $3.3 million for fiscal year 1981, which was the latest available data. Based on the ratio of OTs to PTs (21 percent) in private practice and an estimated annual growth rate of 6 percent from 1981, the Medicare Part B coverage of OT services would add slightly less than $1 million for fiscal year 1985.

For rehabilitation agencies, we have only limited information on physical and occupational therapists. Our estimate of the potential federal costs of extending Medicare coverage to occupational therapists in this setting is very uncertain. Based on the number of occupational therapists relative to those in skilled nursing facilities, we think the annual federal costs are unlikely to exceed the $7 million estimated for covering occupational therapists in skilled nursing facilities. The costs could be substantially less. Our best estimate is that the cost of covering occupational therapists in rehabilitation agencies would be $3 million in 1985; but the costs could range from $1 to $5 million in fiscal year 1985.

The estimate does not include costs associated with coverage of services assisted by certified occupational therapy assistants (COTAs). Currently, COTAs provide a total of 5,000 person-years of service annually in the United States and 4 percent, or 200 person-years, are performed in the three settings. The cost of coverage of COTAs is not quantifiable because of insufficient data on OT services provided to Medicare beneficiaries in these settings.

6. Estimated cost to State and local governments: None.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Diane Burnside.

10. Estimate approved by: C. G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

IV. Other Matters Required to be Discussed Under the Rules of the House

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made: the bill H.R. 5386, as amended, was ordered favorably reported to the House of Representatives by a vote of 19 to 6.

2. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation has been confirmed by oversight investigations conducted by the Subcommittee on Health.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to the Committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

4. INFLATION IMPACT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives with regard to the inflationary impact of the reported bill, the Committee believes that the bill has no measurable effect on health care prices or consumer prices generally.

V. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

[(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies;]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(g) In the case of services described in the [next to last] *second* sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b). *In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).*

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

(2) * * *

* * * * * * *

(C) in the case of outpatient physical therapy services *or outpatient occupational therapy services*, (i) such services are or were required because the individual needed physical therapy services *or occupational therapy services, respectively*, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist *or qualified occupational therapist, respectively*, providing such services and is periodically reviewed by a physician,

and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * * * *

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g))*, or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g))*, but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g) with respect to the furnishing of outpatient occupational therapy services.*

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p) except that "occupational therapy" shall be substituted for "physical therapy" each place it appears therein.

* * * * * * *

MEDICAL AND OTHER HEALTH SERVICES

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(D) outpatient physical therapy services *and outpatient occupational therapy services*;

* * * * * * *

REASONABLE COST

(v)(1)(A) * * *

* * * * * * *

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are fur-

nished under an arrangement with a provider of services or other organization, specified in the first sentence of section 1861(p) (*including through the operation of section 1861(g)*) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (*or meets the requirements of such section through the operation of section 1861(g)*), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (*or meets the requirements of such section through the operation of section 1861(g)*), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or through the operation of section 1861(g) with respect to the furnishing of outpatient occupational therapy services.*)

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98TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPT. 98-1102
Part 1

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1984

SEPTEMBER 28, 1984.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 5989 which on June 29, 1984, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5989) to amend the Social Security Act to protect beneficiaries under health care programs of that act from unfit health care practitioners, and to otherwise improve the antifraud provisions of that act, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert:

SHORT TITLE; REFERENCES IN ACT

SEC. 1. (a) This Act may be cited as the "Medicare and Medicaid Patient and Program Protection Act of 1984".

(b) Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 2. Section 1128 is amended to read as follows:

"EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

"SEC. 1128. (a) The Secretary shall exclude from participation in the programs under title XVIII any individual or entity that has been convicted of a criminal offense related to such individual's or entity's participation in the delivery of items or

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services under title XVIII or under any State health care program (as defined in subsection (e)).

"(b) The Secretary may exclude from participation in the programs under title XVIII the following individuals and entities:

"(1) CONVICTION RELATING TO FRAUD OR PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of health care items or services or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to—

"(A) fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse, or

"(B) neglect or abuse of patients.

"(2) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, or unlawful manufacture, distribution, prescription, or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

"(3) LICENSE REVOCATION OR SUSPENSION.—Any individual who has had the individual's license to provide health care revoked or suspended by a State licensing authority or who otherwise lost such a license for reasons bearing on the individual's professional competence, professional performance, or financial integrity.

"(4) SUSPENSION FROM FEDERAL HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or under a State health care program (as defined in subsection (e)).

"(5) SUBMISSION OF FALSE CLAIMS.—Any individual or entity that the Secretary determines—

"(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under title XVIII or a State health care program or for use in determining the right to a payment under such title or program;

"(B) has submitted or caused to be submitted bills or requests for payment under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for services furnished substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs; or

"(C) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care.

"(6) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is subject to a criminal penalty under section 1128B.

"(7) EXCLUSION OF ENTITIES.—Any entity with respect to which the Secretary determines that a person—

"(A)(i) with an ownership or control interest (as defind in section 1124(a)(3)) in that entity or

"(ii) who is a managing employee (as defined in section 1126(b)) of that entity—

is a person—

"(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1) or (2) of this subsection;

"(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

"(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

"(8) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required of it by section 1124 or section 1126.

"(9) FAILURE TO SUPPLY REQUESTED INFORMATION.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such entity by the Secretary—

"(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, and

"(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.

"(10) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary as may be necessary to verify such information.

"(c) The Secretary may provide for the suspension of payments under title XVIII with respect to items and services furnished by an entity during the period in which the entity fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations)—

"(1) to the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment),

"(2) to the Secretary or the State agency in order to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g), or

"(3) to the Inspector General of the Department of Health and Human Services for the purpose of review of records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

"(d)(1)(A) An exclusion or suspension under this section or under section 1128A shall only be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded or suspended as may be specified in regulations consistent with subparagraph (B).

"(B) Such an exclusion or suspension shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion or suspension; except that such exclusion or suspension shall not apply to payments made under title XVIII or under a State health care program for—

"(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion or suspension, or

"(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion or suspension,

until the passage of 30 days after the date of the exclusion or suspension.

"(C) The notice of exclusion under this section and under section 1128A shall state the earliest date (which, in the case of an exclusion effected pursuant to subsection (a), may not be less than five years after the date of the exclusion) on which the individual or entity may be reinstated under paragraph (4).

"(2) Any individual or entity that is excluded from participation or suspended under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(3)(A) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(4) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each exclusion and suspension effected under this section.

"(B) Each State health care program shall provide for the exclusion from participation in, or suspension of payments under, that program of each individual and entity during any period in which the individual or entity is excluded from participation in, or for which payments are suspended under, the programs under title XVIII pursuant to this section or section 1128A, except that the Secretary may waive such required exclusion or suspension of an individual or entity if the Secretary receives and approves a request for such waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

"(C) The Secretary shall—

"(i) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity ex-

cluded or suspended from participation under this section or section 1128A of the fact and circumstances of such exclusion or suspension.

"(ii) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

"(iii) request that such State or local agency or authority keep the Secretary and the Inspector General in the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

"(4) An individual or entity excluded from participation under this section or section 1128A may apply to the Secretary, at the end of the initial period of exclusion, for reinstatement as a participant in the programs under title XVIII and under State health care programs. The Secretary shall provide for such reinstatement if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion and that there are reasonable assurances that the actions which formed the basis for the original exclusion have not recurred and will not recur.

"(e) For purposes of this section and sections 1128A, 1128B, and 1128C, the term 'State health care program' means—

"(1) a State plan approved under title XIX,

"(2) any program receiving funds under title V or from an allotment to a State under such title, or

"(3) any program receiving funds under title XX or from an allotment to a State under such title.".

CIVIL MONETARY PENALTIES

SEC. 3. (a)(1) Subsection (a)(1) of section 1128A is amended—

(A) by inserting "is false or fraudulent or" in subparagraph (A) after "has reason to know", and

(B) in subparagraph (B), by striking out "section 1128" and all that follows through "proceedings;" and inserting in lieu thereof "this section or sections 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on September 24, 1984), or 1866(b);".

(2) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "In addition the Secretary may make a determination to exclude the person from participation in the programs under title XVIII, subject to the applicable provisions of section 1128(d).".

(3) No civil penalty or damages assessment may be imposed under section 1128A(a) of the Social Security Act in the case of claims filed before August 13, 1981, if such a penalty or assessment could not have been imposed with respect to the claims under section 3729 of title 31, United States Code (relating to false claims).

(b) Subsection (b)(1) of such section is amended by adding at the end the following new sentences: "The Secretary may not initiate an action under this section with respect to any claim later than six years after the date the claim was presented. The Secretary may initiate an action under this section by mailing by registered or certified mail the notice required by paragraph (2)".

(c) Subsections (c), (f), and (g) of such section are each amended by striking out "penalty or assessment" and inserting in lieu thereof "penalty, assessment, or exclusion" each place it appears.

(d) Subsection (e)(1)(A) of such section is amended by striking out "equal to the State's share of the amount paid by the State agency" and inserting in lieu thereof "bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid".

(e) Subsection (g) of such section is further amended by inserting "the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(e))," after "professional organizations,".

(f) Such section is further amended by adding at the end the following new subsections:

"(i) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II.

"(j) Whenever it shall appear to the Secretary that any person has engaged or is engaging in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district

court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.".

CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 4. (a) Section 1909 is amended—

(1) by amending the heading to read as follows:

"CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS";

(2) in subsecton (a)(1), by striking out "a State plan approved under this title" and inserting in lieu thereof "a program under title XVIII or a State health care program (as defined in section 1128(e))";

(3) in the matter in subsection (a) following paragraph (4), by striking out "this title" the first place it appears and inserting in lieu thereof "the program";

(4) in the last sentence of subsection (a), by striking out "this title" the first place it appears and inserting in lieu thereof "title XIX", and by striking out "this title" the second place it appears and inserting in lieu thereof "that title";

(5) in paragraphs (1)(A), (1)(B), (2)(A), (2)(B), and (3)(A) of subsection (b), by striking out "this title" and inserting in lieu thereof "title XVIII or a State health care program" each place it appears;

(6) in subsection (c), by striking out "or home health agency" and "this title" and inserting in lieu thereof "home health agency, or other provider or health care entity" and "for purposes of title XVIII or a State health care program", respectively; and

(7) in subsection (d), by striking out "this title" and inserting in lieu thereof "title XIX" each place it appears.

(b) Subsection (d) of section 1877 is redesignated as subsection (e) and is transferred and inserted in section 1909 at the end thereof.

(c) Section 1909, as amended by subsections (a) and (b) of this section, is redesignated as section 1128B and is transferred to title XI and inserted immediately after section 1128A.

(d) Section 1877 (other than subsection (d) thereof which was transferred under subsection (b) of this section) is repealed.

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS

SEC. 5. (a) Title XI is amended by inserting after section 1128B (transferred pursuant to section 4(c) of this Act) the following new section:

"INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS

"SEC. 1128C. (a) As a condition of approval of a State plan for medical assistance under title XIX, each State must provide for the following:

"(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

"(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

"(B) Any dismisal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

"(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

"(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described such paragraph for the purpose of carrying out this Act.

"(b) The information described in subsection (a)(1) shall be provided to the Secretary (or, under suitable arrangements made by the Secretary, to another entity) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information to licensing authorities described in paragraph (1) and to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(e)), in order for such authorities to determine the fitness of individuals to provide health care services, and in order for such agencies to protect the health and safety of individuals receiving health care through such programs and to protect the fiscal integrity of such programs.

"(c) The Secretary shall provide for suitable safeguards for the confidentiality of such of the information furnished under subsection (a) as is not otherwise available to the public.".

(b) Section 1902(a) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (45),

(2) by striking out the period at the end of paragraph (46) and inserting in lieu thereof "; and ", and

(3) by inserting after paragraph (46) the following new paragraph:

"(46) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners by State licensing authorities in accordance with section 1128C.".

OBLIGATION OF HEALTH CARE PRACTITIONERS AND PROVIDERS

SEC. 6. Section 1156 is amended—

(1) by striking out "title XVIII" and "such title" in subsection (a) and inserting in lieu thereof "this Act" in each instance, and

(2) by striking out "title XVIII" in subsection (b) and inserting in lieu thereof "this Act" each place it appears.

DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION TO MANUFACTURE, DISTRIBUTE, OR DISPENSE A CONTROLLED SUBSTANCE

SEC. 7. Section 304(a) of the Controlled Substances Act (21 U.S.C. 824(a)) is amended—

(1) by striking out "or" at the end of paragraph (2),

(2) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) has been excluded from participation in a program under title XVIII of the Social Security Act pursuant to section 1128(a) of that Act.".

MISCELLANEOUS AND CONFORMING AMENDMENTS

SEC. 8. (a) Section 504(b) is amended—

(1) by striking out "or" at the end of paragraph (4),

(2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(6) payment for any item or service furnished by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(b)(1) Subsection (a) of section 1126 is amended—

(A) in the first sentence, by striking out "or other institution" and all that follows through the period at the end and inserting in lieu thereof "or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who has an ownership or control interest (as defined in section 1124(a)(3)) in such entity, or is a managing employee (as defined in subsection (b)) of such entity, and who is or has been excluded or suspended from participation in a program under title XVIII or in a State health care program described in section 1128(e).", and

(B) in the second sentence, by striking out "institution, organization, or agency" and inserting in lieu thereof "entity".

(2) Subsection (b) of such section is amended by striking out "institution, organization, or agency" and inserting in lieu thereof "entity" each place it appears.

(c) Section 1862 is amended—

(1) by striking out subsection (d), and

(2) by amending subsection (e) to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by an individual or entity during any period when the individual or entity is excluded from participation in a program under this title pursuant to section 1128 or section 1128A.".

(d) Section 1866 is amended—

(1) by striking out paragraph (3) of subsection (a);

(2) by amending subsection (b) to read as follows:

"(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

"(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

"(A) has determined that the provider fails to comply substantially with the provisions of the agreement, or with the provisions of this title and regulations thereunder,

"(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

"(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

"(3) A termination of an agreement or a refusal to renew an agreement under this subsection (and a termination of approval of a supplier under this title) shall be effective on the same date, and with respect to the same items and services, as an exclusion from participation under the programs under this title would become effective under section 1128(d)(1).''; and

(3) by inserting "or has not been renewed" in paragraphs (1) and (3) of subsection (c) after "terminated"; and

(4) by inserting "or nonrenewal" in subsection (c) after "termination".

(e) Section 1869(c) is amended by inserting before the period at the end thereof the following: ", except that an institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues".

(f) Section 1902(a) is amended—

(1) in paragraph (38), by striking out "respectively, (A)" and all that follows up to the semicolon at the end and inserting in lieu thereof "the information described in section 1128(b)(9)", and

(2) in paragraph (39)—

(A) by striking out "bar" and inserting in lieu thereof "exclude",

(B) by striking out "person" and inserting in lieu thereof "individual or entity" each place it appears, and

(C) by inserting "or section 1128A" after "section 1128".

(g) Paragraph (2) of section 1903(i) is amended to read as follows:

"(2) with respect to any amount expended for items or services furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A; or".

(h) Section 1903(n) is amended by striking out "has a direct or indirect ownership or control interest of 5 percent or more" and inserting in lieu thereof "is a person with an ownership or control interest (as defined in section 1124(a)(3))".

(i) Section 2005(a) is amended—

(1) by striking out "or" at the end of paragraph (7),

(2) by striking out the period at the end of paragraph (8) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(9) for payment for any item or service furnished by a person excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

EFFECTIVE DATES

SEC. 9. (a) Except as provided in subsection (b), the amendments made by this Act shall become effective at the end of the 14-day period beginning on the date of the

enactment of this Act and shall not apply to proceedings commenced before the end of such period.

(b)(1) The amendments made by sections 5 and 8(f) apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after April 1, 1985.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretarty of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of this first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) Subsection (j) of section 1128A of the Social Security Act (as added by section 3(f) of this Act) takes effect on the date of the enactment of this Act.

I. INTRODUCTION

PURPOSE

The Committee bill, H.R. 5989, the Medicare and Medicaid Patient and Program Protection Act of 1984, would recodify certain provisions of law relating to medicare and medicaid fraud and abuse and extend them to the maternal and child health program and the title XX social services program. The bill would require a minimum exclusion of five years for individuals or entities convicted of a program-related crime. In addition, it would authorize the Secretary to exclude from medicare, medicaid, the maternal and child health program and the title XX social services program an individual or entity convicted of certain crimes related to the provision of health services or to financial integrity and would authorize the exclusion from medicare, medicaid and the State health care programs in all States a person whose license had been revoked or suspended by any State licensing authority.

The purpose of the recodification is to organize and simplify current provisions related to offenses for fraud and abuse under medicare and medicaid. Further, the additional authority for the Secretary to exclude certain practitioners who have committed crimes or lost their licenses is intended to fill in gaps in the current ability of the Department of Health and Human Services to protect medicare, medicaid and other program beneficiaries from incompetent practitioners.

SHORT SUMMARY

H.R. 5989 would require the Secretary to exclude from medicare and the States to exclude from medicaid, the maternal and child health program under title V, and title XX social services program any individual or entity convicted of a criminal offense related to these programs for a minimum of five years. The Secretary would be permitted to exclude from medicare and, upon such exclusion, the States would be required to exclude from the above State health care programs and individual or entity convicted of certain offenses such as fraud, financial abuse, neglect or abuse of patients, or unlawful distribution of a controlled substance.

The Secretary would be permitted to exclude from medicare and, upon such exclusion, the States would be required to exclude from the above State health programs any individual whose license to

provide health care has been revoked or suspended or who has otherwise lost such a license or been sanctioned under any Federal program involving the provision of health care.

Each State would be required to have in effect a system of reporting the following information with respect to formal proceedings concluded against a health care practitioner or entity by any State authority responsible for health care licensure: (1) any adverse action taken by such licensing authority, including revocation, suspension, reprimand, censure or probation, (2) any dismissal or closure of the proceeding by reason of the practitioner or entity surrendering the license or leaving the State, or (3) any other loss of license. The above information would be provided to the Secretary or, under suitable arrangement to another entity, in order to provide to the Secretary, the State agencies administering the above State health care programs and the State licensing authority information to determine the fitness of individuals to provide health care services, to protect the health and safety of beneficiaries and to protect the fiscal integrity of such plans.

The bill would increase the State's share of civil monetary penalty recoveries.

BACKGROUND AND NEED FOR LEGISLATION

Under current law, the Department of Health and Human Services (HHS) can exclude practitioners from participation in medicare for a number of reasons:

Conviction of a criminal act against medicare (title XVIII, medicaid (title XIX) or title XX of the Social Security Act;

Imposition of a civil monetary penalty for acts against medicare or medicaid;

Submitting false claims to medicare;

Repeatedly providing more services than necessary to medicare beneficiaries;

Submitting medicare claims with charges that substantially exceed the practitioner's customary charges;

Providing services to medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care;

Failing to keep adequate records to demonstrate the need for services rendered.

HHS has the authority to require all States to exclude practitioners from participating in medicaid only when the practitioner is convicted of a criminal act against medicare, medicaid or title XX, or where HHS has imposed a civil monetary penalty on the practitioner for acts against medicare or medicaid.

If HHS excludes a practitioner for the above reasons, HHS is required to notify the State and local agencies responsible for health care licensing or certification of the suspension and request that they invoke sanctions in accordance with applicable State law or policy.

In the last quarter of fiscal year 1983, Secretary Heckler transferred to the Inspector General's (IG) Office from the Health Care Financing Administration (HCFA) the authority to suspend or terminate from medicare and medicaid all health care providers who

engage in fraudulent or abusive practices. During the same period, the Civil Monetary Penalty Law (CMPL), providing tough monetary sanctions, was formally implemented by the Department, further empowering the IG to take action against health providers who abuse or defraud these programs.

On May 1, 1984, the U.S. General Accounting Office (GAO) issued a report to the Secretary of HHS which concluded that there was a need to expand Federal authority to protect medicare and medicaid patients from health practitioners who lose their licenses. The GAO report found that medicare and medicaid patients are being treated in some States by health care practitioners whose licenses were revoked or suspended by another State's licensing board because they did not meet minimum professional standards. This occurred because practitioners move to another State where they have a license and continue to practice. Such practitioners are able to treat medicare and medicaid patients because HHS does not have the authority to exclude them from these programs in all States based on licensing board findings and sanctions in one State. HHS administers medicare and medicaid at the Federal level. Currently, HHS is only empowered to exclude the practitioner in the State in which he or she has lost a license.

Licensing of health care professionals is a responsibility of the States, and practitioners can hold licenses in more than one State. HHS administers medicare and medicaid at the Federal level. To participate in these programs, a practitioner must hold a valid State license. When a State licensing board revokes or suspends a practitioner's license, he or she can no longer legally provide services in the State, and the State licensing boards makes medicare and medicaid aware of this fact. However, sanctioning action by one State does not automatically result in sanctioning by other States where the practitioner holds licenses.

The primary reasons sanctioned practitioners were able to move to other States and continue practice was that other States did not learn of the practitioner's previous offenses, or when they did, many months or years had passed. When States are informed, it takes up to three years to sanction practitioners because procedures are lengthy and there is a shortage of personnel. In addition, State licensing laws may preclude a State from taking action based solely on another State's sanction. Further, physicians whose licenses have been revoked can enter the military and practice without a license from the State in which they are located.

Under current law, HHS can exclude practitioners only for acts committed against medicare, medicaid and their beneficiaries. As a result, HHS excludes relatively few of those sanctioned by State boards. For example, while State licensing boards in Michigan, Ohio and Pennsylvania sanctioned 328 practitioners between 1977 and 1982, HHS nationwide excluded only 335 practitioners from 1975 to 1982. Also, only 15 of the 328 practitioners sanctioned by the three States were also excluded by HHS.

Further, over seventy percent (70%) of HHS exclusion actions were for criminal violations against the programs. However, fifty-eight percent (58%) of the 328 licensing board sanctions in the three States were for problems that affected the practitioners' abil-

ity to meet minimum professional standards or to provide quality care.

In addition, HHS is unable to bar individuals or entities from participation that have been convicted of defrauding private health insurers or defrauding other Federal, State or local government programs.

In summary, HHS currently does not have the authority to exclude individuals or entities from medicare, medicaid, the maternal and child health program and title XX social services program who have been convicted of non-program related crimes such as fraud, financial abuse, neglect of patients or unlawful distribution of a controlled substance. It does not have the authority in all cases to exclude those who have been sanctioned for defrauding or abusing the medicaid program from participation in medicare or vice versa. Further, HHS does not have the authority to exclude nationwide those individuals or entities that have lost their licenses to provide health care or have otherwise been sanctioned by a State licensing authority.

II. Explanation and Justification

Mandatory exclusion for program-related crimes (section 1128(a))

The Secretary would be required to exclude from participation in the medicare program any individual or entity convicted of a criminal offense related to participation in medicare (title XVIII), medicaid (title XIX), the maternal and child health program (title V), or the title XX social services program. The Secretary would be required to exclude the individual or entity for a period of not less than 5 years.

If the Secretary excluded an individual or entity from the medicare program under this provision, the State would be required to exclude such individual or entity from the medicaid, maternal and child health and title XX social services programs for an equal period of time. (Hereafter, the maternal and child health program, and the title XX social services program shall be referred to as the State health care programs.)

This provision expands current law to require a minimum exclusion of five years for crimes related to medicare, medicaid, and the State health care programs. While there is currently a mandatory exclusion from medicare and medicaid for crimes related to medicare, medicaid, or title XX, there is no minimum period of exclusion specified in the law. The Committed believes that such minimum exclusion is appropriate in the case of such crimes. A minimum exclusion of five years provides the Secretary with adequate opportunity to determine whether there is a reasonable assurance that the offense for which the individual or entity was excluded has not recurred and will not recur. Further, such minimum exclusion reduces the need for time consuming administrative reviews of the appropriateness of the length of the exclusion. Finally, the provision would also expand current law to require mandatory exclusion from the maternal and child health and title XX programs of individuals or entites convicted of program-related crimes.

Authority to exclude for certain health-related crimes and crimes related to a controlled substance (section 1128(b)(1) and 1128(b)(2))

The Secretary would be permitted to exclude from participation in medicare individuals and entities convicted of certain criminal offenses not directly related to the program. If the Secretary excluded an individual or entity from medicare on this basis, the State would be required to exclude the individual or entity from medicaid and the other State health care programs for the same period as the exclusion from medicare.

The Secretary would be authorized to exclude any individual or entity convicted of a criminal offense under a State or Federal law either in connection with the delivery of health care or with respect to a program financed or operated by a Federal, State or local government. The criminal offenses for which exclusion would be permitted would be fraud, theft, embezzlement, breach of fiduciary responsibility, financial abuse, or the neglect or abuse of patients.

The Secretary would also be authorized to exclude from medicare, and upon such exclusion, the States would be required to exclude from medicaid and the other State health care programs, any individual or entity convicted under Federal or State law of unlawful manufacture, distribution, prescription or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

Under current law, the Secretary does not have the authority to exclude persons who have been convicted of criminal offenses which are not related to the medicare or medicaid programs. The bill would give the Secretary the authority to protect medicare, medicaid and other beneficiaries against persons who have already been tried and convicted of offenses relating to their financial integrity or which are detrimental to the health and safety of patients.

Authority to exclude for licensure revocation or suspension (section 1128(b)(3))

The Secretary would be authorized to exclude from medicare, and upon such exclusion, the States would be required to exclude from medicaid and the other State health care programs, any individual whose license to provide health care has been revoked or suspended by a State licensing authority or whose license has been otherwise lost for reasons bearing on the individual's professional competence, professional performance or financial integrity.

The Committee heard substantial testimony from the General Accounting Office, based on its investigation of three States, and from the Inspector General of HHS about the need to protect medicare and medicaid patients from practitioners who lose their licenses in one State and move to another. The provisions of this bill would permit the Secretary to exclude such persons from medicare in all States and to require the States to exclude such persons from medicaid and the other State health care programs.

Authority to exclude for suspension related to medicaid Veterans' Administration or other health care programs (section 1128(b)(4))

The Secretary would be authorized to exclude from medicare, and upon such exclusion, the States would be required to exclude from medicaid and the other State health care programs any individual or entity suspended or excluded from participation, or otherwise sanctioned, under any Federal program involving the provision of health care, including health care programs of the Department of Defense, the Veterans' Administration, medicaid or other State health care programs.

Authority to exclude for false statements, excess charges or failure to meet standards of care (section 1128(b)(5))

The Secretary would be permitted to exclude from medicare, and upon such exclusion, the States would be required to exclude from medicaid and the other State health care programs any individual or entity determined by the Secretary to have:

(1) knowingly and willfully made any false statement or representation of material fact in application for payment in any of the above health programs or for use in determining the right to payment under any of these health programs; or

(2) submitted requests for payment under any of the programs which contain charges (or costs) substantially in excess of customary charges; or

(3) furnished items or services to patients (whether or not they are eligible for the above health programs) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care.

This provision recodifies current law under Section 1862(d) requiring denial of medicare payment to persons committing any of the acts mentioned above. The bill would expand current law to require the States to exclude both individuals and entities from medicaid and the other State health care programs. Further, the bill would make it clear that, where excess services were furnished or where there was a failure to provide quality care, the Secretary could look at conduct in relation to patients not in medicare, medicaid or the other State health care programs.

Authority to exclude for fraud, kickbacks and other prohibited activities (section 1128(b)(6))

The Secretary would be permitted to exclude from medicare, and upon such exclusion, the States would be required to exclude from medicaid and the other State health care programs, any individual or entity which has committed an act subject to criminal penalty under the new Section 1128B relating to kickbacks and bribes.

Under current law, a person may be subject to imprisonment or fine under Sections 1909 or 1877 if they have committed certain acts relating to kickbacks, bribes, or false statements. The bill recodifies these provisions and permits sanctions and exclusions from not only medicare and medicaid but from the other State health care programs as well.

Authority to exclude entities controlled, owned or managed by certain persons (section 1228(b)(7))

The Secretary would be permitted to exclude any entity that is owned or controlled by a person, or has a managing employee who has been convicted of an offense related to medicare, medicaid or the other State health care programs described in 1128(a) or an offense regarding fraud, financial integrity or patient abuse as described in 1128(b) (1) and (2), or against whom a civil monetary penalty has been assessed or who has been excluded from participation in medicare, medicaid or any other State health care program. Where an entity was excluded for any of these reasons from medicare, the State would be required to exclude that entity from medicaid and the other State health care programs as well.

The provision recodifies existing authority with respect to excluding entities from medicare which have a close relationship to individuals who have been excluded or sanctioned by the program on the basis of a program-related conviction. The provision would be expanded to provide the Secretary with authority to exclude entities which have a close relationship with individuals who have been excluded for any other offense specified in the bill, or have had a civil monetary penalty imposed against them. In addition, the provision would require the States to exclude such entities from medicaid and other State health care programs.

Authority to exclude entities failing to disclose information (section 1128(b)(8))

The Secretary would be authorized to exclude entities which did not disclose information required by Sections 1124 and 1126 of current law. The Sections require the entities to disclose by whom they are owned or controlled and whether the persons by whom they are owned or controlled are persons who have been convicted of certain offenses.

The provision essentially recodifies current law with respect to medicare and expands it to include medicaid and the other State health care programs.

Authority to exclude for failure to make certain disclosures (section 1128(b) (9) and (10))

The Secretary would be authorized to exclude from medicare, and upon such exclusion, the States would be required to exclude from medicaid and the other State health programs any individual or entity which fails to supply to the Secretary upon request any information relating to the ownership of a subcontractor or information of any significant business transactions. In addition, the Secretary would be permitted to exclude an individual or entity that fails to provide information that the Secretary determines is necessary to determine amounts payable or refuses to permit access or review of materials as requested by, or on behalf of, the Secretary.

These provisions are a recodification of current law under Section 1866(b)(2)(C) except that it is expanded to cover medicaid and the other State health care programs.

Authority to suspend payment for failure to grant access to information (section 1128(c))

The Secretary would be authorized to suspend medicare payments (and the State would be required to suspend payments for medicaid and the other State health care programs) to an entity which, upon reasonable request, refused to grant immediate access to certain information. Access would be required to be granted to the Secretary or the agency designated by the Secretary to perform review for purposes of determining compliance with conditions of participation under Section 1864(a); to the Secretary or the agencies performing certain reviews required under medicaid; and to the Inspector General of the Department of Health and Human Services for purposes of reviewing documents, and other data necessary to the performance of the statutory functions of the Inspector General.

Due process (section 1128(d))

All mandatory and permissible exclusions or suspensions under Section 1128 and 1128A would be effective at such time and upon such reasonable notice to the public and to the individual or entity as may be specified in regulation. An exclusion or suspension would be effective on or after the effective date specified by the notice of the exclusion or suspension, except that payment would be permitted under medicare, medicaid, or a State health care program, for up to 30 days for inpatient institutional services furnished to an individual admitted prior to the exclusion or suspension, and for home health services or hospice care furnished pursuant to a plan established before the date of the exclusion or suspension.

Under the bill, the notice of the exclusion under Section 1128 or 1128A would be required to state the earliest date on which the individual or entity could be reinstated in medicare, medicaid and the other State health care programs. The period could not be less than five years for an exclusion under the program-related crimes provision in Section 1128(a).

The individual or entity excluded or suspended under Section 1128 would be entitled to reasonable notice and opportunity for a hearing by the Secretary and to judicial review of the Secretary's final decision. These are the same hearing and notice requirements provided under present law in Sections 1862(d) and 1128.

The Secretary would be required to notify promptly the appropriate State agencies of the exclusion or suspension under Section 1128. Each State would be required to exclude from, or suspend payment under, its medicaid and other State health care programs for the same period as the medicare exclusion or suspension under Section 1128 or 1128A.

This is essentially a restatement of current law with respect to notice. With respect to required State sanctions, the bill restates current law under Section 1128(a) requiring States to exclude individuals and entities convicted of a program-related crime. With respect to 1128A civil monetary penalties, States would be required to exclude or suspend the individual or entity, rather than the Secretary being permitted to decide whether to direct the States to ex-

clude or suspend such individual or entity. For all other current and new offenses, the State would be required to exclude from, or suspend payment under, medicaid and other State health care programs for the same period as the medicare exclusion or suspension. In addition, as under current medicare law, the Secretary would be permitted to waive the exclusion or suspension from the State program upon the request of the State.

An individual or entity excluded from participation under Section 1128 or the Section 1128A civil monetary penalty provisions would be permitted to apply to the Secretary for reinstatement under medicare, medicaid and the other State health care programs. The Secretary could reinstate such individual or entity if the Secretary determined that there was no basis for a continuation of the exclusion. The Secretary would consider the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion. The Secretary would have to be satisfied that there were reasonable assurances that the actions which were the basis for the original exclusion had not recurred or would not recur.

Civil monetary penalties (section 1128A)

As under current law, the Secretary would be permitted to impose a person or entity a civil monetary penalty (of up to $2,000 per item and an assessment of twice the amount claimed) for any claim that is false or fraudulent or is for a medical or other item or service that was not provided as claimed. Under the bill, the Secretary would be permitted to make a determination to exclude a person or entity against whom a civil monetary penalty is imposed from the medicare, medicaid and the other State health care programs.

The intent of this provision is to provide the Secretary with the opportunity to use a single administrative and unified judicial review procedure for both the civil monetary penalty and the exclusion based on such penalty. In the case of claims filed before August 13, 1981 (the effective date of the civil monetary penalty law), no civil monetary penalty or damages could be imposed which could not have been imposed under the False Claims Act.

Under the bill, the Secretary would not be permitted to initiate an action under the civil monetary provisions later than six years after a claim had been presented. This provision is intended to act in the manner of a statute of limitations. In addition, the Secretary would be permitted to initiate actions by mailing notices by registered or certified mail.

The State's share of funds collected under the civil monetary penalty would be increased. Under current law, the State only recovers its share of the funds paid as a result of false claims. Under the bill, the State would be paid a portion of the total amount collected under the civil monetary penalty in proportion to the State's participation in the original claim.

The intent of the bill is to clarify the scope of the civil monetary provision to include instances of billing twice for the same services and to include submission of claims by "doctors" falsified medical credentials. The bill would accomplish this by adding to the types of those claims that an individual knew or had reason to know

were false or fraudulent. This provision is modeled after the False Claims Act.

The bill would authorize the Secretary to issue and enforce subpoenas with respect to civil monetary penalties to the same extent the Secretary has such authority in other areas of medicare.

If it appears to the Secretary that any person has engaged, or is engaging, in any activity which constitutes a violation which is subject to a civil monetary penalty, the Secretary would be permitted to bring an action to enjoin such activity or to enjoin such persons from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty or to seek other appropriate relief.

This provision was adopted by the Committee because of the difficulty the Inspector General of the Department of Health and Human Services has encountered in preventing persons under investigation for a civil monetary penalty violation from concealing or removing assets in order to avoid paying an imminent penalty.

Criminal penalties for certain fraud and abuse related to medicare and medicaid (section 1128B)

The bill would relocate the kickback, bribe and false statements provisions of medicare (currently Section 1877) and medicaid, (currently Section 1909) into a new Section 1128B. The scope these offenses would be broadened to encompass the maternal and child health program and the title XX social services program.

Information concerning sanctions taken by State licensing authorities against health care practitioners (section 1128C)

A State would be required to have in effect a system of reporting information with respect to formal proceeding concluded against an individual or entity by the State licensing authority.

The State would be required to maintain a reporting system on any adverse actions taken by such licensing authority, including any revocation or suspension of a license, reprimand, censure or probation; any dismissal or closure of a proceeding by reason of the practitioner or entity surrendering the license or leaving the State; also any other loss of license whether by operation of law, voluntary surrender, or otherwise.

The State would be required to provide the Secretary or an entity designated by the Secretary access to such information for purposes of carrying out this Act. The informaton must be supplied to the Secretary or, under other suitable arrangements made by the Secretary, to another entity in such a manner as determined by the Secretary. Information would be required to be provided to State licensing authorities and to medicaid and other State health care programs as well.

The Committee believes that there are other organizations which are currently collecting information on revocation, suspension, censure, and other licensure action against health care professionals which the Secretary might determine could adequately perform collection functions on behalf of the medicare and medicaid programs. The Secretary may find that it is not necessary to duplicate these collection processes. Therefore, the bill would leave to the Secretary the discretion to determine who might most appropriately col-

lect the information. If the Secretary decides to use another organization for the collection and dissemination of information, it is incumbent upon the Secretary to ensure that any organization chosen can provide the information in a timely manner and in such a way as to be useful to the Secretary.

Further, the Committee believes that it would be an excessive burden for the Secretary to collect information on all actions commenced or still pending before a State licensure board. Thus, the bill provides only for the collection of completed actions. Further, the Committee does not believe it is necessary to collect information on exonerations.

The Committee anticipates that the Secretary and the Inspector General of the Department of Health and Human Services may wish to utilize peer review organizations to review the actions of State boards. In the case of a revocation or suspension, the Secretary may wish to use a PRO to determine whether such revocation or suspension involved medical competency, quality of care or financial integrity. In the case of less severe sanctions, the Secretary would be permitted to request that the PRO make a recommendation to the Secretary regarding the need for action and the appropriateness of exclusion from the programs.

The Secretary would be required to provide suitable safeguards to ensure the confidentiality of the information furnished by State licensing authorities.

Obligations of health care practitioners and providers (section 1156)

The bill amends the Peer Review Organization statute, which sets forth the obligations of physicians and other practitioners treating medicare patients to provide quality of care which is medically necessary and appropriately documented, by expanding those obligations to encompass all health care services for which payment may be made under the Social Security Act, not just medicare. Further, exclusions made pursuant to this provision would be from providing any service for which payment would be made under the Social Security Act.

Denial, revocation or suspension of registration to manufacture, distribute or dispense a controlled substance

The bill would amend the Controlled Substance Act to add as a basis for the denial, revocation or suspension of registration to manufacture, distribute or dispense a controlled substance by the Attorney General, any individual or entity that has been convicted of a criminal offense related to such individual's or entity's participation in the delivery of items or services under medicare, medicaid, the maternal and child health program or title XX social services program.

Miscellaneous and conforming amendments

The bill would amend titles V (maternal and child health program), XIX (medicaid) and XX (social services program) to clarify that no payment could be made for any item or service furnished by an individual or entity excluded from participation in those programs.

The bill would also amend title XVIII (medicare) to provide that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both Section 1128 and Section 1866(b) (2) (termination of provider agreements) with respect to a determination or determinations based on the same underlying facts and issues.

In addition, it makes other technical and conforming amendments to the Social Security Act.

Effective dates

The amendments made by this bill would become effective at the end of the 14-day period beginning on the date of enactment and shall not apply to proceedings commenced before the end of such period. The provision giving the Secretary the authority to bring an action to enjoin certain activities would be effective upon enactment.

The provisions of the legislation requiring States to provide the Secretary or the Secretary's designee with information in a form and a manner determined by the Secretary would be effective with respect to medicaid payments for calendar quarters beginning on or after April 1, 1985. Similarly, certain conforming amendments made in medicaid would become effective on the same date.

Where a State is required to enact legislation in order to conform with the requirements of this legislation, the State would not be considered to have failed to meet the requirements before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

III. Budget Effects of the Bill

1. COMMITTEE ESTIMATE

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made: the Committee agrees with the cost estimate prepared by the Congressional Budget Office which is included below. This estimate indicates that there will be no costs associated with this bill.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

With respect to clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee advises that the Congressional Budget Office cost estimate included below indicates that there is no new budget authority or new or increased tax expenditure as a result of the bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 27, 1984.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 5989, as ordered reported by the Committee on Ways and Means on September 26, 1984. This bill amends the Social Security Act to protect beneficiaries under health care programs of that Act from unfit health care practitioners, and to otherwise improve the antifraud provisions of that Act.

Based on this review, it is expected that no additional cost to the government will be incurred as a result of enactment of this legislation. Although certain helath care practitioners will be excluded from participation in medicare, medicaid, the maternal and child health program, and title XX social services, it is expected that beneficiaries will continue to receive the same level of services from other providers.

Sincerely,

ERIC HANUSHEK
(For Rudolph G. Penner, Director).

IV. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of Rule XI of the Rules of the House of Representatives, the following statement is made: the bill H.R. 5989 was ordered favorably reported to the House of Representatives by voice vote.

2. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation has been confirmed by the oversight findings of the Subcommittee on Health. As noted in the above Section on "Background and Need for Legislation," the General Accounting Office presented to the Subcommittee its findings based on its report of May 1, 1984, entitled "*Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses*" (GAO/HRD-84-53). In preparing the report, the GAO reviewed license revocations and suspensions in three States and followed up on the practitioners to determine whether they were still receiving medicare and medicaid reimbursement. Many of the provisions included in this legislation resulted from the recommendations made by the GAO as a result of their investigation.

In addition, the Subcommittee took testimony from the Inspector General of the Department of Health and Human Services who has responsibility for enforcing the fraud and abuse laws designed to protect medicare and medicaid patients. The IG made recommendations to the Subcommittee to expand current authority to fill many

of the gaps in current law. Many of these recommendations were included in H.R. 5989.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of Rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to the Committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

4. INFLATION IMPACT

Pursuant to clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, with regard to the inflationary impact of the reported bill, the Committee believes that the bill has no measurable effect on health care prices or consumer prices generally.

V. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

* * * * * * *

USE OF ALLOTMENT FUNDS

SEC. 504. (a) * * *

(b) Amounts described in subsection (a) may not be used for—

(1) inpatient services, other than inpatient services provided to crippled children or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

[or]

(5) providing funds for research or training to any entity other than a public or nonprofit private entity[.]*; or*

(6) payment for any item or service furnished by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A.

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

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TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

PART A—GENERAL PROVISIONS

* * * * * * *

DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1126. (a) As a condition of participating in or certification or recertification under the programs established by titles XVIII, and XIX, any hospital, nursing facility, [or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.] *or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who has an ownership or control interest (as defined in section 1124(a)(3)) in such entity, or is a managing employee (as defined in subsection (b)) of such entity, and who is or has been excluded or suspended from participating in a program under title XVIII or in a State health care program described in section 1128(e).*

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health and Human Services of the receipt from any [institution, organization, or agency] *entity* of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an [institution, organization, or agency] *entity*, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the [institution, organization, or agency] *entity*, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

[SEC. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary—

[(1) shall bar from participation in the program under title XVIII each such individual otherwise eligible to participate in such program;

[(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such plan for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

[(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

[(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(b) Whenever the Secretary determines, with respect to an entity, that a person who has a direct or indirect ownership or control interest of 5 percent or more in the entity, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such entity, is a person described in section 1126(a), the Secretary—

[(1) may bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such entity otherwise eligible to participate in such program;

[(2) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of the determination, and may require each such agency to bar the entity from participation under the State plan for such period as he specifies, which may not exceed the period established pursuant to paragraph (1); and

[(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or

certification of such entity of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(c) Whenever the Secretary makes a final determination to impose a civil money penalty or assessment against a person (including an organization, agency, or other entity) under section 1128A relating to a claim under title XVIII or XIX, the Secretary—

[(1) may bar the person from participation in the program under title XVIII, and

[(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) may require each such agency to bar the person from participation in the program established by such plan for such period as he shall specify, which in the case of an individual shall be the period established pursuant to paragraph (1), and

[(B) may waive the requirement of subparagraph (A) to bar a person from participation in such program where he receives and approves a request for such waiver with respect to that person from the State agency referred to in that subparagraph.

[(d) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(e) Any person or entity who is the subject of an adverse determination made by the Secretary under subsection (a), (b), or (c) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).]

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) The Secretary shall exclude from participation in the programs under title XVIII any individual or entity that has been convicted of a criminal offense related to such individual's or entity's participation in the delivery of items or services under title

XVIII or under any State health care program (as defined in subsection (e)).

(b) The Secretary may exclude from participation in the programs under title XVIII the following individuals and entities:

(1) CONVICTION RELATING TO FRAUD OR PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of health care items or services or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to—

(A) fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse, or

(B) neglect or abuse of patients.

(2) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

(3) LICENSE REVOCATION OR SUSPENSION.—Any individual who has had the individual's license to provide health care revoked or suspended by a State licensing authority or who otherwise lost such a license for reasons bearing on the individual's professional competence, professional performance, or financial integrity.,

(4) SUSPENSION FROM FEDERAL HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or under a State health care program (as defined in subsection (e)).

(5) SUBMISSION OF FALSE CLAIMS.—Any individual or entity that the Secretary determines—

(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under title XVIII or a State health care program or for use in determining the right to a payment under such title or program;

(B) has submitted or caused to be submitted bills or requests for payment under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for services furnished substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs; or

(C) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care.

(6) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is subject to a criminal penalty under section 1128B.

(7) EXCLUSION OF ENTITIES.—Any entity with respect to which the Secretary determines that a person—

(A)(i) with an ownership or control interest (as defined in section 1124(a)(3)) in that entity or

(ii) who is a managing employee (as defined in section 1126(b)) of that entity—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1) or (2) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

(8) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required of it by section 1124 or section 1126.

(9) FAILURE TO SUPPLY REQUESTED INFORMATION.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such entity by the Secretary—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous 12 months, business transactions in a aggregate amount in excess of $25,000, and

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.

(10) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary as may be necessary to verify such information.

(c) The Secretary may provide for the suspension of payments under title XVIII with respect to items and services furnished by an entity during the period in which the entity fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations)—

(1) to the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment),

(2) to the Secretary or the State agency in order to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g), or

(3) to the Inspector General of the Department of Health and Human Services for the purpose of review of records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(d)(1)(A) An exclusion or suspension under this section or under section 1128A shall only be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded or suspended as may be specified in regulations consistent with subparagraph (B).

(B) Such an exclusion or suspension shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion or suspension; except that such exclusion or suspension shall not apply to payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion or suspension, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion or suspension,

until the passage of 30 days after the date of the exclusion or suspension.

(C) The notice of exclusion under this section and under section 1128A shall state the earliest date (which, in the case of an exclusion effected pursuant to subsection (a), may not be less than five years after the date of the exclusion) on which the individual or entity may be reinstated under paragraph (4).

(2) Any individual or entity that is excluded from participation or suspended under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(3)(A) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each state health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(4) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each exclusion and suspension effected under this section.

(B) Each State health care program shall provide for the exclusion from participation in, or suspension of payment under, that program of each individual and entity during any period in which the individual and entity during any period in which the individual or entity is exclude from participation in, or for which payments are suspended under, the programs under title XVIII pursuant to this section or section 1128A, except that the Secretary may waive such required exclusion or suspension of an individual or entity if the Secretary receives and approves a request for such waiver with

respect to the individual or entity from the State agency adminstering or supervising the administration of the program.

(C) The Secretary shall—

(i) promply notify the appropriate State or local agency or authority having responsibilty for the licensing or certification of an individual or entity excluded or suspended from participation under this section or section 1128A of the fact and circumstances of such exclusion or suspension,

(ii) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(iii) request that such State or local agency or authority keep the Secretary and the Inspector General in the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

(4) An individual or entity excluded from participation under this section or section 1128A may apply to the Secretary, at the end of the initial period of exclusion, for reinstatement as a participant in the programs under title XVIII and under State health care programs. The Secretary shall provide for such reinstatement if the Secretary determines, or the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion and that there are reasonable assurances that the actions which formed the basis for the original exclusion have not recurred and will not recur.

(e) For purposes of this section and sections 1128A, 1128B, and 1128C, the term "State health care program" means—

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title, or

(3) any program receiving funds under title XX or from an allotment to a State under such title.

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity) that—

(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that the Secretary determines is for a medical or other item or service—

(A) that the person knows or has reason to know *is false or fraudulent or* was not provided as claimed, or

(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under [section 1128, 1160(b), or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings;] or *this section or sections 1128, 1156, 1160(b) (as in effect on September 2,*

1982), 1862(d) (as in effect on September 24, 1984), or 1866(b);

(2) presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1),

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each item or service. In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. *In addition the Secretary may make a determination to exclude the person from participation in the programs under title XVIII, subject to the applicable provisions of section 1128(d).*

(b)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty or assessment under subsection (a) only as authorized by the Attorney General pursuant to procedures agreed upon by them. *The Secretary may not initiate an action under this section with respect to any claim later than six years after the date the claim was presented. The Secretary may initiate an action under this section by mailing by registered or certified mail the notice required by paragraph (2).*

* * * * * * *

(2) The Secretary shall not make a determination adverse to any person under subsection (a) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(c) In determining the amount of scope of any [penalty or assessment] *penalty, assessment, or exclusion* imposed pursuant to subsection (a), the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount [equal to the State's share of the amount paid by the State agency] *bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State*

agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out a claim under an allotment to a State under title V, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds.

(3) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

(f) A determination by the Secretary to impose a [penalty or assessment] *penalty, assessement, or exclusion* under subsection (a) shall be final upon the expiration of the sixty-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (d) may not be raised as a defense to a civil action by the United States to collect a [penalty or assessment] *penalty, assessement, or exclusion* assessed under this section.

(g) Whenever the Secretary's determination to impose a [penalty or assessment] *penalty, assessment, or exclusion* under subsection (a) becomes final, he shall notify the appropriate State or local medical or professional organization, *the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(e)),* and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a [penalty or assessment] *penalty, assessment, or exclusion* has become final and the reasons therefor.

* * * * * * *

(i) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section ot the same extent as they are applicable with respect to title II.

(j) Whenever it shall appear to the Secretary that any person has engaged or is engaging in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

[PENALTIES] *CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS*

SEC. [1909.] *1128B.* (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under [a State plan approved under this title,] *a program under title XVIII or a State health care program (as defined in section 1128(e)),*

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under [this title,] *the program*, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under [this title] *title XIX* is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of [this title] *that title* or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the elibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program*, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in

whole or in part under [this title,] *title XVIII or a State health care program,*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program,* or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program,*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under [this title] *title XVIII or a State health care program*; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, [or home health agency] *home health agency, or other provider or health care entity* (as those terms are employed in [this title,] *for purposes of title XVIII or a State health care program* shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under [this title,] *title XIX,* money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under [this title,] *title XIX,* any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(The following subsection (d) which is redesignated 1128B(e) has been transferred from section 1877 by the bill.)

[(d)**]** *(e)* Whoever accepts assignments described in section 1842 (b)(3)(B)(ii) or agrees to be a participating physician or supplier under section 1842(h)(1) and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS

SEC. 1128C. (a) As a condition of approval of a State plan for medical assistance under title XIX, each State must provide for the following:

(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described such paragraph for the purpose of carrying out this Act.

(b) The information described in subsection (a)(1) shall be provided to the Secretary (or, under suitable arrangements made by the Secretary, to another entity) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information to licensing authorities described in paragraph (1) and to State agencies administering or supervising the administration of State

health care programs (as defined in section 1128(e)), in order for such authorities to determine the fitness of individuals to provide health care services and in order for such agencies to protect the health and safety of individuals receiving health care through such programs and to protect the fiscal integrity of such programs.

(c) The Secretary shall provide for suitable safeguards for the confidentiality of such of the information furnished under subsection (a) as is not otherwise available to the public.

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PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

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OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1156. (a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under [title XVIII,] *this Act,* to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under [such title] *this Act*—

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under [title XVIII,] *this Act,* has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to pro-

vide such services on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective at such time and upon such reasonable notice to the public and to the practitioner or person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in [title XVIII] *this Act* with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART C—MISCELLANEOUS PROVISIONS

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EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

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[(d)(1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

[(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

[(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

[(C) has furnished services or supplies which are determined by the Secretary on the basis of information acquired by the Secretary in the administration of this title to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.

[(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, posthospital extended care services, and home health services such determination shall be effective in the manner provided in section 1866(b) (3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(4) The Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of any determination made under the provisions of this subsection.

[(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1128 from participation in the program under this title.]

(e) No payment may be made under this title with respect to any item or service furnished by an individual or entity during any period when the individual or entity is excluded from participation

in a program under this title pursuant to section 1128 or section 1128A.

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

[(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a).

[(b) An agreement with the Secretary under this section may be terminated—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determined whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has fur-

nished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126(a).

Any termination shall be applicable—

[(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

[(4)(A) with respect to home health services or hospice care furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual more than 30 days after such effective date, and

[(5) with respect to any other items and services furnished on or after the effective date of such termination.]

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, or with the provisions of this title and regulations thereunder,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection (and a termination of approval of a supplier under this title) shall be effective on the same date, and with respect to the same items and services, as an exclusion from participation under the programs under this title would become effective under section 1128(d)(1).

(c)(1) Where an agreement filed under this title by a provider of services has been terminated *or has not been renewed* by the Secretary, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination *or nonrenewal* has been removed and that there is reasonable assurance that it will not recur.

(2) In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910(a), and the term of any

such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.

(3) Where an agreement filed under this title by a provider of services has been terminated *or has not been renewed* by the Secretary, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination.

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DETERMINATIONS; APPEALS

SEC. 1869. (a) * * *

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(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), *except that an institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.*

* * * * * * *

[PENALTIES

[SEC. 1877. (a) Whoever—

[(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

[(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

[(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

[(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment

is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

[(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

[(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

[(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

[(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

[(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

[(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a felony and upon conviction thereof shall be

fined not more than $25,000 or imprisoned for not more than five years, or both]

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

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(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, [respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor] *the information described in section 1128(b)(9)*;

(39) provide that the State agency shall [bar] *exclude* any specified [persons] *individual or entity* from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 or section 1128A and provide that no payment may be made under the plan with respect to any item or service furnished by such [person] *individual or entity* during such period;

* * * * * * *

(44) in each case for which payment for inpatient hospital services, skilled nursing facility services, intermediate care facility services, or inpatient mental hospital services is made under the State plan—

(A) a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6) (or, in the case of services that are intermediate care care facility services provided in an institution for the mentally retarded, every year), and accompa-

nied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1912; [and]

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act[.]; *and*

(47) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners by State licensing authorities in accordance with section 1128C.

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PAYMENT TO STATES

SEC. 1903. (a) * * *

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(i) Payment under the preceding provisions of this section shall not be made—

[(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or]

(2) with respect to any amount expended for items or services furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A; or

* * * * * * *

(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who [has a direct or indirect ownership or control interest of 5 percent or more] *is a person with an ownership or control interest (as defined in section 1124(a)(3))* in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section

1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866[1]); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.

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TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES

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LIMITATIONS ON USE OF GRANTS

SEC. 2005. (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

(7) for any child day care services unless such services meet applicable standards of State and local law; [or]

(8) for the provision of cash payments as a service (except as otherwise provided in this section)[.]; *or*

(9) for payment for any item or service furnished by a person excluded from participation in the program under this title pursuant to section 1128 or section 1128A.

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SECTION 304 OF THE CONTROLLED SUBSTANCES ACT

DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION

SEC. 304. (a) A registration pursuant to section 303 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the Attorney General upon a finding that the registrant—

(1) has materially falsified any application filed pursuant to or required by this title or title III;

(2) has been convicted of a felony under this title or title III or any other law of the United States, or of any State, relating to any substance defined in this title as a controlled substance; [or]

(3) has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances[.]; *or*

(4) has been excluded from participation in a program under title XVIII of the Social Security Act pursuant to section 1128(a) of that Act.

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